STATE OF MICHIGAN

IN THE SUPREME COURT

JOHANNA WOODARD and STEVEN WOODARD, Individually, and JOHANNA WOODARD as Next Friend of AUSTIN D. WOODARD, a Minor,

Plaintiffs/Appellants/Respondent

vs.

JOSEPH R. CUSTER, M.D.,

Defendant/Appellee/Petitioner,

and

JOHANNA WOODARD and STEVEN WOODARD, Individually, and JOHANNA WOODARD as Next Friend of AUSTIN D. WOODARD, a Minor,

Plaintiffs/Appellant/Respondent,

vs.

UNIVERSITY OF MICHIGAN MEDICAL CENTER,

Defendant/Appellee/Petitioner.

Supreme Ct.
Nos. 124994-95

Court of Appeals
No. 239868
Washtenaw Circuit Court
No. 99-5364-NH
Hon. Timothy P. Connors

CASE CONSOLIDATED AND JOINED WITH:

Court of Appeals
No. 239869
Court of Claims
No. 99-17432-CM

124994-5

PLAINTIFFS/APPELLANTS'/RESPONDENTS' BRIEF IN RESPONSE TO DEFENDANTS' APPLICATION FOR LEAVE TO APPEAL

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STATEMENT OF APPELLATE JURISDICTION

These joined actions for medical malpractice against the University of Michigan Medical Center (Court of Claims action) and the action against the hospital's doctor (Washtenaw Circuit action) were dismissed by a February 7, 2002 order (entered on the court's docket sheet on February 12, 2002). The Claim of Appeal in both actions was filed February 27, 2002, and within 21 days of both the dating of the order and its entry on the docket sheet. By order dated April 23, 2002 the Court of Appeals consolidated the appeals. On October 21, 2003 the Court of Appeals issued its opinion. On November 12, 2003 the defendants Hospital and Doctor filed their application with the Supreme Court. The application is timely under MCR 7.302(C)(2)(b), and this Court can exercise jurisdiction under MCR 7.301(A)(2).

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COUNTER-STATEMENT OF QUESTIONS PRESENTED

I. ARE PLAINTIFFS ENTITLED TO INVOKE *RES IPSA LOQUITUR* WHERE IT IS WITHIN THE COMMON UNDERSTANDING OF LAYMEN THAT AN INFANT WHO IS HOSPITALIZED FOR BREATHING DIFFICULTIES SHOULD NOT ORDINARILY SUSTAIN TWO BROKEN LEGS DURING HIS HOSPITALIZATION ABSENT SOMEONE'S NEGLIGENCE, THE DEFENDANTS WERE IN CONTROL OF THE INFANT'S BODY AND OTHER CAUSES WERE ELIMINATED?

Plaintiffs/Appellants/Respondents say:	"Yes"
Defendants/Appellees/Petitioners say:	"No"
Court of Appeals says:	"Yes"
Trial Court says:	"No"

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STATEMENT IN RESPONSE TO REQUEST FOR REVIEW

Defendants' unwarranted attack on majority decision of the Court of Appeals in this matter (targeting Judge Borrello), and defendants shameful pandering to Judge Talbot's distorted view of the facts, is cringe worthy.

In reviewing the defendant's "Statement of Need for Supreme Court Review", one must wonder what in the world the defendants are talking about. Their so called "statement" is a diatribe which does not get this Court any nearer to what this case is about.

This case concerns a child who had healthy unbroken legs, who was hospitalized for breathing difficulties, and ended up with two broken legs during the hospitalization. It defies common sense for defendants to argue, as they do, that it is beyond the common ken of ordinary persons to understand that such should not occur absent negligence. The record evidence, as more fully articulated in the following brief, amply supported the right of plaintiffs to take this case to trial applying the doctrine of *res ipsa loquitur*. A scrutiny of the record will establish that Judge Talbot went on a fact finding mission (certainly not a judicial function at this level) and ignored the evidence which supported plaintiffs' claim. Judge Borrello clearly understood this and properly viewed the evidence in light most favorable to the plaintiffs. With the concurring opinion of Judge Meter, the majority decision of Judges Borrello and Meter should stand. This Court should deny leave.

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COUNTER-STATEMENT OF FACTS

Overview

These joined cases arise out of the occurrence of two broken legs to a newborn during hospitalization for a breathing problem. The pending claims against the hospital and attending physician/director of the pediatric intensive care unit sound in malpractice for use of improper force while performing pediatric procedures which caused two bilateral femur fractures. The fracture of the left leg was into the growth plate and as a result the infant now has a shorter left leg which will require surgery. The case was dismissed because the trial judge determined that plaintiffs' expert, albeit board certified in pediatric medicine, did not match the exact subspecialties of the remaining named defendant physician. Further, the court would not permit plaintiffs to invoke the doctrine of *res ipsa loquitur* notwithstanding the elements of that doctrine were met: The infant was in the defendants' control; all other causes were eliminated; plaintiffs are unable to prove the actual occurrence of the event; and the defendant doctor has admitted it would be a breach of the standard of care if the fractures occurred during the mishandling of the newborn and/or misapplication of force by the medical staff.

Underlying Facts

Austin Woodard, (born January 15, 1997), 15 days old, presented to the University of Michigan Hospital on January 30, 1997 with suspected respiratory syncytial virus (RSV). Earlier that day, Austin was seen by his pediatrician, Dr. John Kennedy, who recommended Austin be transported via EMS to the University of Michigan Hospital because of his breathing difficulties. (**Ex A, Dr Kennedy records**). The total hospitalization for this problem was from January 30, 1997 through February 28, 1997. However, during Austin's first 12 days of hospitalization (from January

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30 through February 10, 1997) while a patient in the Pediatric Intensive Care Unit (PICU), he sustained two broken legs; both discovered upon transfer to another unit. Defendant Dr. Joseph Custer M.D., the hospital's director of the PICU, was responsible for the PICU staff. **(Ex L, Dr. Custer, pp 3, 5).**

During the 12 days in the PICU, Austin underwent several medical procedures, including the following: On January 30, 1997, Austin was intubated to provide respiratory assistance. **(Ex L, Dr. Custer, pp 15-16).** He remained intubated through February 9, 1997, was sedated, and received feedings through a feeding tube during that time. On January 31, an arterial line was placed in his right groin. On February 1, he had a blood transfusion, supposedly to increase his red blood cells. On February 2, a central venous catheter was placed in his left groin area. On February 6, the right arterial line was removed. **(Ex P-Dr. Casamassima dep, pp 48-52).**

On February 7, the left central venous catheter was removed. **(Ex L, Custer, pp 15-16).** It was bent at the site and leaking clear fluid. **(Ex B, 2/7/97 critical care flowsheet)**. The hospital records also show on February 9 (hospital day number 11), that Austin was becoming extremely agitated; even though he was significantly sedated he awakened easily and had long drawn out crying spells.

As stated above, during his admission in the PICU, Austin was intubated from January 30 to February 9, 1997 and required ventilation to assist his breathing. He ate from a feeding tube. During this time, Austin's parents were unable to hold and/or feed him. Austin's parents were kept out of Austin's room during procedures, such as intubation and line insertions, and could not stay in the room overnight with him. **(Ex C, J. Woodard Dep, pp 18-19, 23, 26)**. Austin was on a feeding tube until February 9, 1997, so his mother was not able to nurse Austin either. **(Ex C, J.**

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Woodard Dep, p 11). Austin's mother, Johanna Woodard, testified that she had to call on someone from the hospital staff to get into the PICU area where she could see Austin. (**Ex C, J. Woodard, pp 18, 26**). Furthermore, Mrs. Woodard was kept from seeing her infant son on one particular occasion; she was told the hospital personnel were having difficulty inserting a line into Austin so she could not see him. (**Ex C, J. Woodard Dep, pp 26-31**). Another infant patient, Brianna Reynolds, was sharing the room with Austin at this time. Brianna's mother, Kendra Reynolds, later told Mrs. Woodard that she saw the hospital personnel having trouble with Austin's line insertion, and saw a lot of blood before the hospital personnel asked Mrs. Reynolds to leave the room. (**Ex D, J. Woodard Dep Trns, pp.38-40**).

Kendra Reynolds testified as to the incident in the PICU. While visiting her daughter, several medical personnel began to perform what Ms. Reynolds recognized as a line insertion on Austin, and Austin began bleeding profusely. The medical personnel became panicky in their demeanor, and quickly thereafter asked Ms. Reynolds to leave the room. (**Ex D, Reynolds Dep, pp 9-13**). The incident was described by independent witness Kendra Reynolds as follows:

"Q Back to this incident we were taking about now, can you tell me what you recall observing that day?
A Okay. I was in there and like about six doctors – I'm not saying for sure it was six, but it was about six doctors both female and male had went in there. And they were standing on both sides of his bed, and they were hovering over him trying to put the line in.
Q When you say "the line in," what are you referring to?
A The line in his legs? Is that what you mean?
Q Yes. How did you know they were putting a line in his leg? That's what I am trying to find out.
A A few days before that they were trying to put a line in Brianna's leg, and it didn't take or whatever. So I just kind of assumed that there would be no other reason to be cutting his leg.
Q All right.
A Which I'm guessing it was a line. And then **they panicked**. **Because when they cut**

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him, there was tons of blood; and they shut the curtain as fast as they could. And they asked me to leave.

Q Did you hear any of the doctors say anything before you left?

A Just like gasping because -- well, his tube had popped out; and he started to wake up. When they cut him, he came off his intubation; and they needed to medicate him some more.

Q Was Austin making any noise that you recall?

A Yeah. That's what Austin had -- that's when she shut the curtain is when he -- the tube popped out, and he started crying.

Q Was it--

A And that was about the time that they were trying to cut him.

Q All right. When you looked over, how did you see -- you used the term that there was -- I don't know remember exactly -- quite a bit of blood. How did you know there was quite a bit of blood?

A I could see it. **It was all over**. I mean -- when I say all over, **it was all over the side of his bed and on his leg and then just blood was coming out still**.

Q Do you recall that Ms. Dembinski – Nancy here talked to you sometime ago on the phone?

A Uh-huh.

Q Do you remember making a comment to her something to the effect that you heard the doctors say, oh, no or something like that?

Mr. Reynolds: That's a leading question. Form.

Q (By Mr. Nemier) I'm just trying to refresh your recollection.

A I'm not sure what he said. I'm pretty sure it was a gasp. They were all kind of mumbling. They were more just kind of get her out of here, you know. **They were just kind of panicking**.

Q And then what happened?

A **Then they asked me to leave**." **(Ex D, Reynolds Dep, pp10-13)**.

No notation of this event was made anywhere in Austin's medical records from the University of Michigan Hospital.

On February 10 (hospital day number 12), Austin was to be transferred from the PICU to the general hospital floor. The February 10, 1997, 11:30 a.m. nursing transfer note reflects: "Becomes very agitated, and turns red in the face, cries." **(Ex E, 2/10/97 nursing note).** Leg swelling was not noted. However, at 1:00 p.m., just before Austin was transferred from the PICU to the general floor on February 10, the same nurse noted in a "transfer note addendum" that: "**Leg greatly swollen due**

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to CVP line pulled a few days ago, also infant had both legs pulled up under him impeding venous return." **(Ex E, 2/10/97 nursing note)**. In addition it is undisputed that the nursing flow sheet record for February 10, 1997 indicated that the left leg was edematous and purple. Also, undisputed on February 10, 1997, a third year medical student noted that: "Left leg edema due to venous lymphatic stasis." Further, after the catheter was pulled, the infant slept with his knees drawn up. **(Ex L, Custer, pp 27-28).**

By February 11 (hospital day 13), Austin's left leg was still swollen and was tender to touch. **(Ex L, Custer, p 30).** Although deep vein thrombosis (DVT) was suspected, apparently someone believed something else was occurring, and Austin was sent for an x-ray. **(Ex L, Custer, p 30-31).** Dr. Custer admitted a fracture can cause a DVT in trauma patients. (Id. p 30). The radiologist reported that there was a minimally displaced comminuted fracture involving a left distal femur, possibly extending into the growth plate. **(Ex F, 2/11/97 radiologist report)**. Following this, Dr. Randall Loder, a University of Michigan pediatric orthopedic surgeon (a children's bone specialist), was consulted the evening of February 11. He felt fracture was likely, although there could be an "occult infection"[1] and they would follow up on repeat x-rays. **(Ex G, 2/12/97 consultation report).**

A full skeletal survey was performed on February 13 (hospital day 15), revealing both left and right femur fractures, with the left extending into the growth plate. **(Ex H, 2/13/97 radiologist report)**. In the follow up consult of February 13, Dr. Loder confirmed there was a fracture of the left femur, as well as what he felt was a slightly older fracture on the right. **(Ex I, Loder Dep, pp**

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[1]"Occult" means hidden or concealed. See Attorney's Dictionary of Medicine, Vol 3, pp 0-12 (1984). Thus the doctor had a concern of a bone infection. Osteomyelitis is an infection of bone. Attorneys' Textbook of Medicine, 3rd Ed, p 2-76 (1983).

12-16). Thus the fracture for the left femur was discovered February 11 (hospital day 13) and the fracture of the right femur was discovered February 13 (hospital day 15). Both fractures were adjacent to the growth plate. (Id. pp 12-13, 15-16). Contrary to the defendants' assertions, and Judge Talbot's misstatement of the facts, Loder testified that the fracture on the left was fresh "within seven days, something like that". (Id. Loder Dep, p 12). He agreed that fracture would have occurred sometime during the admission to the hospital. (Id.) The fracture on the right was discovered February 13 (hospital day 15). Dr. Loder opined that it was a slightly older fracture, and the amount of callus usually takes 14 to 21 days. (Id., p 16). Recall, this is the 15th day of Austin's hospitalization and the right fracture too was within the medical realm of having occurred during Austin's hospitalization. Indeed, Dr. Loder specifically mentioned both to Drs. Custer and Owings that the dating of the fractures raised the possibility that they could have been inflicted by staff at the hospital. **(Ex I, p 29).**

> "Q. Inasmuch as going on the ranges for the fractures, clearly the left occurred during the hospitalization and possibly the right one could have as well; did you consider the possibility that someone on staff at the University of Michigan could have inflicted those injuries?
>
> A. Well, *that's why I know I mentioned that to Dr. Custer at the time and to Dr. Owings.*
>
> Q. Could you recall - not the exact words, but the substance of your concern in that regard?
>
> A. *The concern is is there someone inflicting the injuries.*
>
> Q. And potentially on staff?
>
> A. *Potentially on staff."* (Id., p 29).

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After reviewing the films with the radiologist again, Dr. Loder opined that the fracture was traumatic and not pathologic. **(Ex I, 2/13/97 Loder consultation report)**. Thus, Dr. Loder ruled out osteomyelitis as a cause of the fractures.[2]

On May 22, 1997, Austin saw University of Michigan geneticist, Dr. Jeffrey Innis, who determined that brittle bone disease was not the cause of Austin's fractures. **(Ex I, Loder Dep, p 28; Ex K, 5/22/97 Innis report)**.

There is no notation in the University of Michigan Hospital records which suggest any indication that Austin may have come into the hospital with bilateral fractures. **(Ex L, Custer Dep, p 40)** To the contrary, there are references in the medical records suggesting the fractures occurred during Austin's stay in the PICU. **(Ex L, Custer Dep, pp 40-41).** In particular, the discharge summary for Austin's second inpatient admission (due to seizures he developed) notes, "Orthopedics. He sustained bilateral femur fractures during the last hospitalization." **(Ex M, 3/7/97 discharge summary)**. Also an inpatient note on 3/10/97 indicates the femoral fracture on the left was due to procedure in the ICU. **(Ex N, 3/10/97 in-patient note)**.

As to the cause of Austin's fractures, defendant Dr. Custer, director of the PICU, suggested that there was either child abuse, or substandard care. Absent involvement of the parents, he admitted that if the fractures occurred in his unit from mishandling or misapplied force, that would be below the standard of care. **(Ex L, Custer, pp 35-36).**

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[2]In January 2001, Austin was evaluated by a second University of Michigan orthopedic surgeon, Dr. Farley. Dr. Farley is a specialist in leg lengthening procedures and a colleague of Dr. Loder. Dr. Farley considers Dr. Loder to be a good doctor, and was of the opinion that the probability of Dr. Loder missing osteomyelitis if it existed was "very low." **(Ex J, Farley Dep, pp 17-18)**. Dr. Farley examined Austin and found a leg length discrepancy due to the fracture which may require surgery. **(Ex J, Farley Dep, p 6-8)**.

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"Q. Let's ask it a little differently. Speaking to the hospital and not necessarily to yourself, let's assume that while he was in the pediatric critical care, that sometime during that stay, the fractures occurred and it had nothing to do with the parents. Would you agree with me that certainly would be below what you see the standard of care for treatment of an infant under these circumstances?

A. If the fractures occurred from mishandling and wrongly applied mechanical force, yes, **it would be below the standard of care**. **(Ex L, Custer Dep, pp 35-36)**.

Defendant Dr. Custer is board certified in pediatrics, with certifications in subspecialties of pediatric critical care medicine and neonatology-perinatology. **(Ex L, Custer Dep, p 4).** He is not an orthopedic (bone) specialist. Austin was officially on Dr. Custer's service, as the director of the PICU at the University of Michigan Hospital, while Austin was a patient in the PICU, i.e. from January 30, 1997 until his transfer to the general floor on February 10, 1997. **(Ex L, Custer Dep, pp 3-4, 66-67)**. Dr. Custer was in contact with Austin Woodard in two ways, (1) as an attending physician, and (2) as the director of the medical physicians that work in the PICU. **(Ex L, Custer Dep, p.5)**

Dr. Custer admits there is no evidence indicating the fractures occurred before Austin's admission to the hospital's pediatric care unit. **(Ex L, Custer Dep, pp 40-41).** Further, Custer saw no evidence from the records from anyone to give an indication anyone thought the child had come in with bilateral fractures. **(Id. at 40).** He had spoken to other doctors and physicians who had concluded that the injuries occurred during the stay in the critical care unit. **(Id. p 41)**. Also, on the issue of dating the fractures, Dr. Custer stated he himself was unable to date the injuries and did not come to any conclusions as to when either fracture occurred. **(Id. p 34)**. In addition a patient, such as Austin, is sedated and given muscle relaxants; they are anesthetized and have to be moved by nurses to change positions. **(Id p 47).**

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Following discovery of the two fractures, Dr. Custer contacted Dr. Clyde Owings, head of the University of Michigan Child Protection Unit. **(Ex L, Custer, pp 32-33).** Dr. Owings was an Associate Professor in the Department of Pediatrics, in communicable diseases, as well as on U of M's Engineering Teaching Staff. **(Ex O, Owings Dep, pp 4-6).** Dr. Owings investigated the possibility of child abuse as a cause of the fractures. He reviewed the x-ray films, talked to the radiology department and other treating physicians, examined Austin, and came to the conclusion that this was not a case of child abuse and therefore did not report it. (**Ex O, Owings Dep, pp 28-29**). Dr. Owings also testified he could not date the fractures. **(Id. p 13).** In addition, he found the radiologists whom he spoke to were not of any benefit to him in trying to date the fractures. **(Owings, p 30).** He apparently also spoke to Dr. Custer concerning his opinion on the injuries. Dr. Custer related what Owings reported to him, "He thought the injuries were mechanical in nature, the fractures were mechanical in nature, to be correct, and that he could not date them." **(Ex L, Custer, p 33).**

Defendants assert Dr. Owings did not rule out child abuse. Dr. Owings own testimony contradicts defendants' assertion; in fact, Dr. Owings could not find any reasonable cause to suspect child abuse:

A: My responsibility is if there is a reasonable cause to suspect abuse or neglect, then I make a report to Children's Protective Services.

Q: FIA?

A: Yes. Which is part of the Family Independence Agency. And if a patient is hospitalized they notify the police, but I don't call the police.

Q: I take it in this case you didn't do that?

A: That's correct. **(Ex O, Owings, p. 24).**

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Later in his deposition, he confirmed that had he thought it was child abuse, he would have made a report:

Q: Was that your basic thing that you didn't think it was child abuse in this case?

A: If I would have thought it was child abuse, I would have reported it. **(Ex O, Owings, p 28)**.

Thus, there was no reasonable basis to make any claim of child abuse. Defendants' brief suggests otherwise, but with absolutely no supporting evidence. Strangely, in his 19 years doing this work, this is the only case where Dr. Owings did not keep a file/record of his investigation. **(Ex O, Owings Dep, p 37)**.[3]

During discovery, it was made clear to plaintiffs that it would be virtually impossible for plaintiffs, or any expert on behalf of plaintiffs for that matter, to point to the specific individual(s) or procedure(s) performed at University of Michigan Hospital which caused Austin Woodard's bilateral femur fractures. Dr. Casamassima, plaintiffs' liability expert, candidly admitted this lack of direct evidence in his discovery deposition in August 2001. **(Ex P, Casamassima Dep, pp 4, 7-8)**. However, Dr. Casamassima outlined several procedures which were performed on Austin during his stay in the PICU which could have caused the fractures, such as positioning during insertion of the femoral venous line and/or femoral arterial line, positioning during intubation, or manual hip rotation maneuvers. **(Ex P, Casamassima Dep, pp 10-11)**. None of these procedures would ordinarily have a femoral fracture as a known complication. **(Ex P, Casamassima Dep, pp 70-71)**. Dr.

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[3]Not only did they rule out child abuse, the hospital also paid all the medical bills (obviously to mitigate the damages should suit follow), including payment of the follow up treatment right up to the hearing on defendants' motion for summary disposition. **(Ex M, 10-12-01 Trans pp 4-6).** Defendants did not deny paying for those bills. **(Ex M, Trans p 14).**

Casamassima has knowledge of the amount of force required to create a fracture, based upon his education and experience as a pediatrician who has dealt with a number of pediatric fractures, both traumatic and pathological. **(Ex P, Casamassima, pp.11-12)**.

Dr. Casamassima further testified that a child such as Austin would be subject to the hospital staff's manipulation more often than anyone else, even the parents:

"Q. So if you step back from the list of procedures [that Dr. Casamassima listed as possible sources of the injury] what you are really looking at, if you take away the name procedure, what you are really looking at is moving this kid's legs in some way, right? That is what those procedures involve?

A. Correct.

Q. We know that no one was excluded from touching this child, right? Parents were not told, Do not try to comfort your baby. Do not try to touch your baby?

A. No. I assume somebody could not just walk in off the street and touch the baby, but certainly the parents weren't excluded.

Q. We are talking about people who were authorized to be in the PICU room?

A. Right.

Q. So assuming that – paraphrasing what you said – **a simple negligent moving of a leg in the wrong direction with too much force unknowingly, assuming it is that, why is it more likely to be a staff person as opposed to someone else**?

A. **Well, when a child's hospitalized frankly, it's under the care and treatment of that hospital and it is frankly more often manipulated by the staff than by the parents especially in these settings**.

Q. For you in general then, it is a matter of statistical likelihood?

A. **And because the parents were excluded according to Dr. Owings as far as being the cause of the fractures**." **(Ex P, Casamassima Dep, pp 86-87)**.

Dr. Casamassima is board certified in pediatrics. **(Ex P, p 67).** Between December 1993 to

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March 1998 he was the Director of Medical Affairs of the Richmond Children's Center. This is 110-bed facility for developmentally disabled children. During that time he had only clinical patient loads, as well as supervising three other physicians and the pediatric nurse practitioner. **(Ex P, pp 63-64).** Three-quarters of his time at the Richmond Center was clinical patient care and the rest, administrative. As a member of the New York Medical College faculty, which funded the center, he supervised residents under four-week rotations. These were pediatric residents. **(Ex P, pp 65-67).**

While subsequently (March 1998), he changed careers and is now a practicing attorney, during the year prior to the underlying incident here (between January 30 and February 10, 1999), Dr. Casamassima devoted a majority of his professional time to the active clinical practice of pediatrics, and as well, was involved in the instruction of students serving their general pediatrics residency rotations through the Richmond Clinic. Previous to this, between September 1986 and May 1991, he was the associate director of the medical genetics subdepartment of the New York Medical College Dept. of Pediatrics. Dr. Casamassima has a subspecialty in genetics.

However, during the relevant time frame of the year prior to the underlying incident, his work was as the Director of Medical Affairs at the Richmond Children's Center, with his clinical practice confined to the practice of general pediatrics. **(Ex P, pp 63-67).**

PROCEDURAL HISTORY - MOTION PROCEEDINGS

On October 4, 1999, plaintiffs, Johanna Woodard as Next Friend of Austin D. Woodard, a minor, and Johanna and Steven Woodard, Individually, filed a two count complaint in the Court of Claims against the University of Michigan Medical Center, a state hospital, in the Court of Claims,

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alleging negligence and/or medical malpractice, and negligent infliction of emotional distress.[4] Plaintiffs' complaint and the affidavit of merit of Dr. Casamassima alleged breach of the standard of care as to the hospital in failing: (1) to properly treat and monitor Austin with the degree of care required so as not to fracture Austin's bones, (2) to properly insert an arterial line so as to subject Austin to a loss of blood requiring a transfusion, (3) to properly monitor Austin after insertion of the femoral line and allowing him to lay on one side for over an hour causing Austin's leg to swell and sustain deep vein thrombosis, and (4) to properly monitor Austin after placement of the arterial lines and femoral venous lines to prevent onset of line sepsis, subsequent bacterial infection, causing Austin to have multiple cerebral infarctions. **(Ex Q, Ct of Claims Complaint & Aff of Merit)**.[5]

On October 7, 1999, plaintiffs, Johanna Woodard as Next Friend of Austin D. Woodard, a minor, and Johanna and Steven Woodard, Individually, also filed an action for medical malpractice in the Washtenaw County Circuit Court against the individual University of Michigan Medical Center physicians - Dr. Joseph Custer, Michael K. Lipscomb, M.D., Michele M. Nypaver, M.D., and Mona M. Riskalla, M.D., jointly and severally. This complaint, and affidavit of merit by Dr. Casamassima, alleged the same breaches of the standard of care applicable to the physicians as was alleged against the hospital. **(Ex R, Washtenaw Co Complaint & Aff of Merit)**.

On February 10, 2000, the cases were joined pursuant to MCL 600.6421 with Washtenaw County Circuit Court Judge Timothy P. Connors sitting for both cases.

3-31-00 Defendants' First Motion for Summary Disposition

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[4]It was agreed, later, that the emotional distress claims of the parents would be dropped. **(Ex T, Trans 9/14/01, pp 4-5).**

[5]The affidavit was filed January 4, 2000 under MCL 600.2912(d)(3) since defendants failed to timely allow access to the medical records. **(Ex S, Trans 3/31/00, pp 9-12).**

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On March 31, 2000, defendants moved for summary disposition pursuant to MCR 2.116(C)(4), (C)(5), and (C)(7), alleging, *inter alia*, that plaintiffs' affidavits of merit were late and not signed by a physician whose specialty matched that of the defendants. The court found that defendant Dr. Custer is board certified in pediatrics, with board certified sub-specialization in neonatology and critical care medicine. The other doctors were also board certified in pediatrics, with subspecialties; one student was a resident rotating through the pediatric intensive care unit, and another doctor was a resident in pediatrics. (**Ex S, 3/31/00 Hearing Trns, p 9**). The court found that Dr. Casamassima was also board certified in pediatrics, and that the affidavits of merit met the requirements of MCL 600.2169 (1), stating:

> "The plain language of the statute indicates that specializations are to be taken into consideration but does not mention sub-specializations. As the defendant doctors and Dr. [Casamassima] share a board certified specialization in pediatrics, the affidavit of merit is signed by a health profession who plaintiff's attorney reasonably believes meets the appropriate requirements, therefore summary disposition is inappropriate and defendant's motion is denied." (**Ex S, 3/31/00 Trns, p 12**).

Subsequently, Drs. Lipscomb, Nypaver, and Riskalla, were dismissed upon stipulation by the parties without prejudice, and are not parties to this appeal.

9-14-01 Motion to Strike Plaintiffs' Expert

In August 2001, Dr. Custer filed a motion for summary disposition under MCR 2.116(C)(10), asserting that since plaintiffs' expert could not identify the individual agent, doctor or employee who caused the fractures of Austin's legs, the doctor could not testify as to the appropriate standard of care and summary disposition should be granted. Both defendants jointly moved to strike Dr. Casamassima as an expert, asserting that he was unqualified under MCL 600.2169[6]. In addition,

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[6] In light of its ruling striking plaintiffs' expert, the court did not render an opinion on the substance of defendants' motions for summary and partial summary disposition, which were also

both defendants also moved for partial summary disposition to strike portions of the plaintiffs' Complaint. On September 14, 2001 the motions were brought on for hearing. Ultimately the trial court granted the defendants' joint motion to strike Dr. Casamassima as an expert. Defendants argued that Dr. Custer and the employees of the medical center against whom plaintiffs brought their claims were practicing pediatric intensive care medicine. Defendants asserted that since plaintiffs' board certified pediatrician, Dr. Casamassima, did not practice in the sub-specialty of intensive care medicine, that he was not qualified to give expert testimony in these matters. **(Ex T, 9/14/01 Hearing Trns, pp 14-16)**.

In response, plaintiffs argued that Dr. Casamassima was qualified in pediatric care, the area in which plaintiffs assert the malpractice occurred, that the statute did not require a subspecialty match. In addition it was argued expert testimony might not be necessary under the facts and circumstances of the case in light of the doctrine of *res ipsa loquitur* and Dr. Custer's admission. **(Ex T, 9/14/01 Hearing Trns, pp 18-23)**. Since this is a case where an otherwise healthy 15-day old infant with a respiratory virus sustains two broken legs while under the care and control of the defendants, plaintiffs were entitled to proceed even without expert testimony under the *res ipsa loquitur* doctrine. **(Ex T, 9/14/01 Trns, pp 18-21)**.

The court opined that per the deposition testimony of Dr. Casamassima:

> "One, between December 1993 and March of 1998, none of his clinical practice involved pediatric critical care medicine; two, he has no experience or training as an attending physician in a pediatric intensive care unit; three, he has no specialty training in pediatric hematology, pediatric infectious diseases; four, the last time he inserted a central venous line in, performed an intubation on, or inserted a central arterial line in a 15 month old infant was during his residency in the early 1980's;

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scheduled for argument. **(9/14/01 Hearing Trns, pp 29-32)**. Also, plaintiffs conceded to dismissal of Johanna and Steven Woodard's claims for negligent infliction of emotional distress.

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five, he became a full-time lawyer in March of 1998; and six, his pediatric practice contains approximately two days per week in the context of a home for mentally disabled children, in which arena he performs no work as the attending physician responsible for the patient's care.

Considering this testimony, this Court finds that Dr. [Casamassima] did not devote a majority of his time within the year preceding the injury to the same active clinical speciality as Dr. Custer or the staff of the pediatric intensive care unit. Dr. [Casamassima] admitted that he had no experience with pediatric critical care within one year prior to the injury complained of." **(Ex T, 9/14/01 Trns, pp 30-31)**. (Emphasis added).

In finding that plaintiffs' expert was not qualified under MCL 600.2169, and plaintiffs therefore having no expert testimony to support their claims, the court dismissed plaintiffs' complaints. **(Ex T, 9/14/01 Hearing Trns, p 32)**. The court did not give an opinion on whether plaintiffs' action fell into one of the exceptions (such as *res ipsa loquitur*) whereby such expert testimony is not necessary. Plaintiffs' counsel orally moved the Court for an extension of time to secure a new expert, which the court denied, stating that issue was not properly before the Court on a motion. **(Ex T, 9/14/01 Hearing Trns, pp 32-33)**. Plaintiffs then filed motions for a determination on the necessity of an expert; for an extension to secure another expert; and to amend the Complaints to invoke *res ipsa loquitur*.

10-12-01 Motions

On October 12, 2001, hearing took place on plaintiffs' motion for a determination by the court that dismissal of plaintiffs' causes of action were not required since plaintiffs' cases fell under one or more exceptions to the general rule requiring expert testimony in professional malpractice, or in the alternative, for an extension of time to secure a pediatric expert with sub-specialization in critical care medicine in substitution for Dr. Casamassima. The motion to amend the complaints to both dispense with some of its allegations on breaches of the standard of care and to invoke the

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doctrine of *res ipsa loquitur,* were also heard. **(Ex V, 10/12/01 Hearing Trns).** Plaintiffs' proposed amended (consolidated) complaint alleged the elements of *res ipsa loquitur*, and breaches of the standard of care as to the positioning or performance of line insertions and/or other maneuvers upon Austin so as to cause his fractured femurs. **(Ex U, amended complaint).**

Plaintiffs further argued since defendants injured portions of Austin's body which were free of disease and not designated for treatment, under Michigan case law and the doctrine of *res ipsa loquitur*, no expert testimony was necessary. **(Ex V, 10/12/01 Hearing Trns, pp 4-13).** In addition, it was argued if the court determined expert testimony was necessary, then plaintiffs could elicit the expert testimony upon cross-examination of Dr. Custer as to the standard of care and breach thereof. Indeed Dr. Custer had already given that testimony. **(Ex V, 10/12/01 Hearing Trns, pp 12-13).** Defendants asserted plaintiffs needed expert testimony to establish breaches of the standard of care, and since the court struck plaintiffs' only expert, that the cases should be dismissed. **(Ex V, 10/12/01 Hearing Trns, pp 16-20).**[7] The court took the motions under advisement. (Id. p 25).

By written order and opinion dated February 7, 2002, the trial court denied plaintiffs' motion to amend their complaint to specifically invoke the doctrine of *res ipsa loquitur*, finding that "irrespective of whether justice requires this Court to permit amendment, the amendment requested is futile absent medical testimony to support the causes pled." **(Ex W, 2/7/02 opinion and order, p 5).** The court found that expert testimony would still be necessary, even when using *res ipsa loquitur*, in considering whether Austin's fractures could have occurred in the absence of someone's negligence. **(Ex W, 2/7/02 opinion and order, pp 5-6).** The court also denied plaintiffs' request

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[7]Also up for hearing was defendants' motion to enter the dismissal order based on the September 14 bench ruling.

in the interest of fairness for an extension of time to substitute its expert, based upon the fact defendants challenged plaintiffs' affidavit of merit early in the proceedings, and since the scheduled trial date was two months away. **(Ex W, 2/7/01 opinion and order, p 6)**. The order dismissed plaintiffs' complaints with prejudice. **(Ex W, 2/7/01 opinion and order, pp 6-7)**.[8]

COURT OF APPEALS' DECISION

Following the trial court's rulings and entry of dismissal orders, plaintiffs appealed. The Court of Appeals rendered its written unpublished opinion on October 21, 2003. **(COA Dockets 239868; 239869).** The decision split on the two primary issues; 1) whether plaintiffs' expert's qualifications had to match a sub-specialty of the defendant doctor, and 2) whether plaintiffs were entitled to invoke the doctrine of *res ipsa loquitur* and proceed without an expert, if it were determined that no expert would be permitted. Judges Talbot and Meter (based on Judge Talbot's written opinion), determined that there had to be a match in sub-specialties. Judge Borrello dissented on that issue, noting that both plaintiffs' expert and the defendant doctor were board certified in the particular specialty at issue, general pediatric care, and that it was abuse of discretion to the trial court to exclude an expert board certified in the specialty at issue. Plaintiffs are Cross Applying for Leave on the majority decision (Talbot and Meter) concerning the expert.

On the *res ipsa* issue, Judge Borrello issued the majority opinion focusing on the core factual issue (i.e. one for trial) of when and how Austin's femurs broke. He framed the issue on the *res ipsa* question as follows:

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[8]The court also preemptively denied plaintiffs a motion for reconsideration **(Ex W, p 2, fn 1);** however, the reference by the court to such a motion is incorrect; plaintiffs in their motion to amend had mentioned in a footnote they "intended" on filing for reconsideration of the court's ruling striking their expert. No motion for reconsideration had yet been filed; with the trial court's preemptive ruling, it became futile.

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"...is expert testimony necessary in a case where an infant is taken to a hospital for treatment of RSV bronchiolitis and somehow develops two broken femurs?" **(Borrello Op, p 2).**

Judge Borrello correctly stated the doctrine of *res ipsa loquitur* and its application in the case law. **(Borrello Op, pp 5-6).** Referencing the cases cited, Judge Borrello stated:

> "In those cases, the courts determined that expert testimony was not a prerequisite to recovery because whether the acts in question were careless and not in accord with standards of good practice in the community was within the common knowledge and experience of the lay jurors. Likewise here, I find that where a child presented to the hospital for RSV bronchiolitis and developed two broken femurs, the doctrine of *res ipsa loquitur* applies and expert testimony is unnecessary.
>
> Additionally, because we are bound to view the evidence in a light most favorable to the non-moving party, and because the defendant presented no contrary evidence, the inference must be granted to plaintiffs that Austin's femurs were healthy at the time of admission. In fact, because Austin was undisputedly admitted to the hospital for treatment of RSV bronchiolitis and not for treatment of his legs, this case is analogous to the fact patterns set forth in *Higdon, supra.*
>
> In *Higdon, supra,* at 366-367, a patient was having dentistry performed when the dentist's drill slipped and cut her tongue. Relying upon numerous cases from other jurisdictions, our Supreme Court held that a jury may infer negligence from "lay proof" in cases where "healthy and undiseased parts of the body requiring no treatment are injured during the professional relationship, under circumstances where negligence may be legitimately inferred." Id. at 374-376.
>
> In this case, Austin presented to the hospital to be treated for RSV bronchiolitis and subsequently sustained two broken femurs. A lay person can understand that RSV bronchiolitis is not connected to broken femurs and can infer negligence. Expert testimony is not necessary when an injury occurs to a healthy and undiseased body part that did not require treatment. *Higdon, supra* at 374-376. Viewing the evidence in the light most favorable to the non-moving party, Austin's injuries were to parts of his body which at the time of admission we must infer were healthy and undiseased. I, therefore, find our Supreme Court's ruling in *Higdon* controlling. Accordingly, the trial court erred what it held that expert testimony was required." **(Borrello's Op, p 6).**

Judge Talbot in his "dissenting" opinion, instead of viewing the evidence in a light most favorable to the plaintiff, viewed the evidence in the light most disfavorable to the plaintiff and in

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a highly selective manner. In essence, Judge Talbot engaged in fact finding. Judge Talbot ignored the testimony of the orthopedic surgeon, a bone specialist, (Loder) who placed the fracture of the left femur during Austin's stay in the PICU. Instead he relied on testimony of Dr. Owings, a professor at the Medical School teaching pediatric communicable diseases and the investigator on the child abuse unit. He also ignored the testimony of Dr. Owings that Owings could not date the fractures, rather Judge Talbot relied on the speculation of Owings on the dating. Judge Talbot also ignored Dr. Custer's testimony that he could not date the fractures and who admitted that there was no evidence that the infant had come into the hospital with fractures. Instead Judge Talbot relied on speculation of Dr. Custer not ruling out the "possibility" of him having come to the hospital with fractures. In addition, Judge Talbot relied on Dr. Custer's speculation that there might be brittle bone disease, ignoring that a geneticist had examined and tested Austin, and determined that brittle bone disease was not the cause of the fractures. Dr. Loder, as pointed out above, testified that the cause of the fractures was traumatic, and not pathological.

In essence, Judge Talbot engaged in an improper weighing of evidence and fact finding, when the question here is did the plaintiffs present evidence to support their claim sufficient to proceed to trial under the *res ipsa loquitur* doctrine. It is submitted that Judge Borrello properly viewed the evidence and the majority decision issued by Judge Borrello and Meter, permitting plaintiff to proceed to trial, should stand and the defendants' Application for Leave should be denied.

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ARGUMENT

I.

PLAINTIFFS ARE ENTITLED TO INVOKE *RES IPSA LOQUITUR* WHERE IT IS WITHIN THE COMMON UNDERSTANDING OF LAYMEN THAT AN INFANT WHO IS HOSPITALIZED FOR BREATHING DIFFICULTIES SHOULD NOT ORDINARILY SUSTAIN TWO BROKEN LEGS DURING HIS HOSPITALIZATION ABSENT SOMEONE'S NEGLIGENCE, THE DEFENDANTS WERE IN CONTROL OF THE INFANT'S BODY AND OTHER CAUSES WERE ELIMINATED.

A trial court's decision to grant or deny summary disposition is reviewed *de novo*. McDonald v PKT Inc., 464 Mich 322, 332 (2001). In reviewing motions for summary disposition under MCR 2.116(C)(7) and (10), the court considers the pleadings, affidavits, depositions and other documentary evidence submitted by the parties in the light most favorable to the party opposing the motion. Tate v Detroit Receiving Hospital, 249 Mich App 212, 215 (2002).

Defendants have a deliberately skewed view of the facts when they assert that if a jury were to sit this case it would be "on the basis of nothing more than the fact that this infant was diagnosed with femur fractures while he was hospitalized, without any reasonable basis for a jury to conclude that the fractures were due to any act, neglect or otherwise, on part of the hospital staff." Defendants Application p 21. There is more than a reasonable basis for a jury to conclude that the fractures did indeed occur during the hospital and while Austin was in control of the defendants, and that the fractures could only have occurred because of neglect or mishandling by the hospital staff. The evidence shows that the fracture on the left was broken during Austin's admission at the PICU. No contrary evidence has been provided by the defendants; only speculation and conclusory statements. The evidence also shows that the fracture of the right leg, which was almost the same type fracture

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as that on the left, could have occurred during the first day of Austin's admission. While defendants point to Dr. Owings and Dr. Custer as "opining" that the potential of the fractures (both) occurring before admission were not "ruled out", neither of those doctors is a bone specialist (an orthopedic doctor), as is Dr. Loder. Other causes of such fractures were eliminated. Dr. Loder reported that the injuries were traumatic, not pathological (thus eliminating disease processes). Dr. Loder also eliminated osteomyelitis. The geneticist eliminated brittle bone disease. In addition, if child abuse were a cause, the investigating doctor, Owings, would have filed a report. He testified that he did not file a report and could not conclude that there was child abuse. The parents were not permitted to hold or feed Austin while he was in the PICU. The hospital staff, on the other hand, did handle and maneuver Austin which if done improperly or with too much force could have caused the fractures. Their activities included positioning during insertion of the femoral venous lines and/or femoral arterial line, positioning during intubation, as well as manual hip rotation. Contrary to the defendants' assertions and Judge Talbot's selective viewing of the defendants' proferred testimony, there is more than sufficient evidence for a jury to infer than an infant who comes to a hospital with healthy legs and sustained fracture during the hospitalization, suffered the injury due to the negligence of the hospital staff.

The trial court's decision here to dismiss the case was based on disqualification of plaintiffs' expert and the proposition that without an expert, plaintiffs could not proceed with the medical malpractice claim against the defendants. The court relied on Greathouse v Rhodes, 242 Mich App 221 (2000), for that proposition. **(Ex T, 9/14/01 Trns, p 30).** Greathouse has subsequently been reversed by the Supreme Court on other grounds [465 Mich 885 (2001)].

However, plaintiffs did present and did support an alternate ground for proving their case of

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malpractice under the doctrine of *res ipsa loquitur*. Under law, a case can proceed under the doctrine even without the necessity of an expert witness, even in a medical malpractice case.

Proof of a medical malpractice case requires the demonstration of four factors: (1) the applicable standard of care; (2) breach of that standard of care by the defendants; (3) injury to plaintiffs; and (4) proximate causation between the alleged breach and the injury. MCLA 600.2912a; Locke v Pachtman, 446 Mich 216, 222 (1994); Wischmeyer v Schanz, 449 Mich 469, 484 (1995). Since issues of negligence and causation "are normally beyond the ken of laymen," expert testimony is usually required to establish the standard of care, breach of the standard of care by the defendant, and causation. Thomas v McPherson Center, 155 Mich App 700, 705 (1986). However, as acknowledged by the Thomas Court, there are exceptions to the requirement of expert testimony in this regard.

> "There are two closely connected exceptions to this requirement. [1.] **Where the negligence claimed is 'a matter of common knowledge and observation,' no expert testimony is required**. Daniel v McNamara, 10 Mich App 299, 308; 159 NW2d 339 (1968). And, [2.] **where the elements of the doctrine of *res ipsa loquitur* are satisfied, negligence can be inferred**. Neal v Friendship Manor Nursing Home, 113 Mich App 759; 318 NW2d 594 (1982)." Thomas v McPherson Center, 155 Mich App 700, 705 (1986). (Emphasis added).

Plaintiffs' case fits both of these exceptions.

A. No Expert Testimony is Needed Since Defendants' Negligence in Fracturing Austin Woodard's Legs is Within the Common Understanding and Experience of Laymen

To fracture an infant patient's legs during his hospital stay for treatment for a respiratory virus is so obviously negligent that a layperson needs no expert testimony in order to find malpractice.

Expert testimony is not normally required where the defendant mistakenly treats or does

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injury to a portion of the body that was free of disease and not designated for treatment. Locke v Pachtman, 446 Mich 216, 228 (1994); Higdon v Carlebach, 348 Mich 363, 374 (1957); Sullivan v Russell, 417 Mich 398, 408 (1983).

In Higdon, the plaintiff's dentist was using an electrically driven separating disk to prepare a place for a band between the plaintiff's teeth when her tongue was cut by the device. Higdon, at 365-367. Defendant claimed that plaintiff moved her tongue and it contacted the disk. Plaintiff claimed she did not move. Higdon, at 366-367. Defendant argued expert testimony tending to show that the requisite degree of professional care had not been exercised was necessary. Plaintiff argued the doctrine of *res ipsa loquitur* applied, and her case fell within a recognized exception that where there is direct proof that healthy and undiseased parts of the body requiring no treatment are injured during the professional relationship, under circumstances where negligence may be legitimately inferred, no expert testimony is required. Higdon, at 369-374.

Justice Black, writing for four justices, agreed that no expert testimony was necessary under the facts presented. Higdon, at 377. Justice Carr, concurring with Justice Black and writing for the remaining four members of the court, opined separately that the case was truly not one for medical malpractice, but one of ordinary negligence in whether there was due care in using the electrically driven disk equipment. Higdon, at 378. He therefore agreed that no expert testimony was necessary. Higdon, at 378.

A similar decision was reached in Sullivan v Russell, 417 Mich 398, 408 (1983). There, the Supreme Court held no expert testimony was necessary where the defendant dentist mistakenly ground several of plaintiff's healthy teeth which were not intended for treatment.

Austin Woodard sustained injury to healthy and undiseased body parts which were not

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intended for treatment. Austin Woodard was being treated by the University of Michigan Hospital for RSV, i.e., a respiratory infection causing him difficulty breathing. Clearly, the treatment for breathing difficulty is extraneous to the portion of his body ultimately injured - - his legs. Therefore, like the situations in Higdon and Sullivan, no expert testimony is necessary here in order for a layperson to find malpractice on the part of Defendants.

B. No Expert Testimony is Necessary Since Plaintiffs are Entitled to an Inference of Negligence Under the Doctrine of *Res Ipsa Loquitur*

Another exception to the need for expert testimony in a medical malpractice case involves the doctrine of *res ipsa loquitur*; i.e., where plaintiff is entitled to a permissible inference of negligence from the circumstantial evidence. Jones v Porretta, 428 Mich 132, 150 (1987). If a plaintiff's case satisfies this doctrine, then the case may proceed to the jury without expert testimony. Locke v Pachtman, 446 Mich 216, 230 (1994). The facts and circumstances of this case meet these requirements.

Where a medical malpractice plaintiff raises the theory of *res ipsa loquitur*, the plaintiff must prove that the event: (1) is of a kind that ordinarily does not occur in the absence of someone's negligence, (2) is caused by an agency or instrumentality within the exclusive control of defendant, and (3) is not due to any voluntary action or contribution on the part of the plaintiff, and (4) the explanation is more accessible to the defendant than the plaintiff. Jones v Porretta, 428 Mich 132, 150-151 (1987); Thomas v McPherson Center, 155 Mich App 700, 706 (1986). When *res ipsa loquitur* is applied, it raises an inference of negligence which a defendant may attempt to explain away or avoid. "The question of whether the inference of negligence is avoided requires a weighing of the proofs and must be left for the trier of fact." Neal v Friendship Manor Nursing Home, 113

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Mich App 759, 765 (1982).

Plaintiffs satisfy all of the elements necessary to proceed on a theory of *res ipsa loquitur*:

(1) This event is not of a kind that ordinarily occurs in the absence of negligence.

The fact that the injury complained of does not ordinarily occur in the absence of someone's negligence must be either supported by expert testimony or be within the common understanding of laymen. Locke v Pachtman, 446 Mich 216, 231 (1994); Jones v Porretta, 428 Mich 132, 154 (1987). As argued above, the factual situation present - infant plaintiffs' legs being fractured while he was being treated as an in-patient for a respiratory virus - is so grossly obvious as to be within the common understanding of the jury. See, e.g., Higdon v Carlebach, 348 Mich 363 (1957).

Furthermore, even the director of the PICU, Dr. Custer, has testified that if the fractures occurred in the PICU it would be below the standard of care:

> "Q. Let's ask it a little differently. Speaking to the hospital and not necessarily to yourself, let's assume that while he was in the pediatric critical care, that sometime during that stay, the fractures occurred and it had nothing to do with the parents. Would you agree with me that certainly would be below what you see the standard of care for treatment of an infant under these circumstances?
>
> A. If the fractures occurred from mishandling and wrongly applied mechanical force, yes, **it would be below the standard of care**.
>
> (**Ex A** - Dr. Custer Dep Trns, pp.35-36)

Dr. Custer's testimony in this regard is significant in that plaintiffs are not required to produce their own expert witness to establish the applicable standard of care, but are permitted to call defense witnesses as adverse witnesses, per MCL 600.2161, and cross-examine them. Therefore, either standard is met in this case so as to satisfy this first element.

(2) This event was caused during infant Plaintiff's hospitalization when he was within the exclusive care and control of defendants

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Austin was a patient under the exclusive care and control of the University of Michigan Hospital, and specifically the PICU, when his fractures occurred. During his admission Austin was intubated from January 30 to February 9, 1997 and required ventilation to assist his breathing. He ate from a feeding tube. During this time, Austin's parents were unable to hold and/or feed him. The University of Michigan medical personnel, however, had control and access to him. For example, consider the numerous procedures the hospital staff performed on him during that time, including a right femoral arterial line, left femoral central venous line, catheter, and peripheral IVs.

Defendants argued they did not have "exclusive" control over young Austin, since his parents were allowed to see him while he was at the hospital. However, just because Austin could have visitors under the supervision of the hospital staff, did not mean the defendants did not have exclusive control over Austin for the purposes of proving this element of *res ipsa loquitur*.

Indeed, the applicable jury instruction, SJI2d 30.05, does not speak to "exclusive control", rather, it provides:

> **"Medical Malpractice: Permissible Inference of Malpractice from Circumstantial Evidence (*Res Ipsa Loquitur*)**
>
> If you find **that the defendant had control over** [*the body of the plaintiff or the instrumentality which caused the plaintiff's injury*], and that the plaintiff's injury is of a kind which does not ordinarily occur without someone's negligence, then you may infer that the defendant was negligent.
>
> However, you should weigh all of the evidence in this case in determining whether the defendant was negligent and whether that negligence was a proximate cause of plaintiff's injury." (Emphasis added)
>
> Additionally, the note on use provides, in the pertinent part:
>
> "This instruction should be given only if there is expert testimony that the injury does not ordinarily occur without negligence, **or** if the court finds that such a determination could be made by the jury as a matter of common knowledge."

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(Emphasis added)

Just because a patient can have supervised visitors, such as his parents, who can touch him during his hospitalization, does not mean the hospital did not have control over the conduct causing plaintiffs' injury. If this were the case, control could never be proven when a patient had visitors who were allowed to touch him. As explained below, this is not the type of "control" this element contemplates.

In Thomas v McPherson Center, 155 Mich App 700 (1986), plaintiff underwent a tubal ligation at McPherson Medical Center. The procedure was performed by two named defendant physicians who were not agents of the center. Plaintiff was found to have a perforation in her small bowel and filed suit against the center and the physicians. Thomas, at 702-703. Plaintiff relied upon the inference of negligence absent expert testimony, relying upon the doctrine of *res ipsa loquitur*. Thomas, at 706. The Court of Appeals opined that plaintiff could not meet the second element of the doctrine since the health care center did not have exclusive control concerning the negligent conduct causing plaintiff's injury. This was because the health center merely providing operating facilities to the defendant physicians who performed the actual tubal ligation, who were not agents of the health center. Thomas, at 706-707.

Austin Woodard's case is not one wherein the defendant hospital merely provided the facilities while the plaintiff was a patient of physicians of another medical center. It is undisputed that the physicians and staff who treated Austin were employees or agents of the University of Michigan Medical Center. The defendants certainly had the requisite control of the medical procedures performed upon Austin, and control of Austin's body to manipulate it as necessary to perform the procedures. Austin's parents obviously did not perform medical procedures on Austin,

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and in fact, Austin's parents were not even allowed in the same room when procedures were being performed.

Austin's parents were kept out of Austin's room during procedures, such as intubation and line insertions, and could not stay in the room overnight with him. **(Ex C - Johanna Woodard Dep, pp 18-19, 23, 26)**. Austin was on a feeding tube until February 9, 1997, so Johanna Woodard was not able to nurse Austin either. **(Ex C - J. Woodard, p 11)**. Johanna Woodard testified that she had to call on someone from the hospital staff to be able to get into the PICU area where she could see Austin. **(Ex C - J. Woodard, pp 18, 26)**. Furthermore, Johanna was kept from seeing Austin on an occasion, and was told it was because the hospital personnel were having difficulty inserting a line into Austin so Johanna could not see him. **Ex C - J. Woodard, p.26-31)**. In addition, the incident where Austin was cut and bleeding extensively during insertion of a line was witnessed by Kendra Reynolds, whose testimony was quoted, supra.

Also, Defendants have asserted that perhaps child abuse was a possible cause of Austin's leg fractures. However, the University of Michigan Medical Center's Child Protection Unit, Dr. Clyde Owings, performed an investigation and came to the conclusion that this was not a case of child abuse and therefore did not report it. **(See Ex O, Dr. Owings Dep Trns, pp 28-29)**. Also, oddly enough, Dr. Owings stated that in his 19 years doing this work, this is the only case where he did not keep a file/record of his investigation. **(Ex O, Dr. Owings Dep Trns, p 37)**.

This was not a case of child abuse, and the Defendants had exclusive care and control over Austin for purposes of this element.

(3) Austin's fractures were not due to any of his voluntary actions or contributions

It has never been an issue, and it would indeed be an absurd assertion with no evidence to

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support the contention that Austin Woodard, a newborn infant less than one month old, voluntarily contributed to his leg fractures. This is especially absurd where Austin was sedated, intubated, on muscle relaxants and had numerous lines inserted for nourishment and catheterization.

(4) The explanation for the cause of Austin's fractures is more accessible to the defendants than the plaintiffs

Defendants in this case are also in a better position to know how it was Austin sustained leg fractures during his admission. After all the hospital staff (specifically, Dr. Custer's PICU staff) were the ones performing the medical procedures and inherent manipulation of the minor Plaintiff, including the abnormally bloody line insertion described by independent witness Kendra Reynolds:

What is interesting about that incident is the fact that there is absolutely no reference in the chart to anything relating to this incident. In fact, Dr. Custer who did an investigation following the discovery of the bilateral femur fractures, denies that anything unusual occurred during Austin's stay in the intensive care unit. Obviously, however, something traumatic did in fact occur, and an explanation for that occurrence is more accessible to the defendant medical care providers.

Defendants attempt to argue (but present no evidence) that a bone infection, osteomyelitis, caused the fractures. However, Dr. Loder testified that he had Austin evaluated by Dr. Innis for bone diseases or complications, and it was concluded no evidence supported that the fractures were caused by such a disease or process. (Ex I, Loder dep p. 28) Dr. Loder himself found no evidence of such condition during the time that he followed Austin's case. Id. Dr. Loder followed up with Austin's treatment for over a year, up to July 1998. Id. pp. 28, 32. Defendants presented no countervailing evidence. In addition, as mentioned above, defendants mis-characterize Dr. Owings' testimony regarding the child abuse investigation. Dr. Owings found no reasonable basis to conclude that child

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abuse existed and, as a result, he did not report it. In other words, he ruled it out. Thus defendants' argument on complications or other causes is without merit.

This case is a classic *res ipsa loquitur* scenario. A child with healthy legs goes to a hospital for treatment of a respiratory condition and ends up with two broken legs while heavily sedated and in the control of the defendants. Defendants' citation to Jones v Poretta, 428 Mich 132 (1987); Wilson v Stilwill, 411 Mich 587 (1981); and Paul v Lee, 455 Mich 204 (1997), is misplaced. This is not, as defendants would have the court believe, a case involving a bad result from treatment of a particular injury or a failure of judgment by the doctor and the diagnosis or treatment of a particular injury; it is a case where healthy legs, not designated for treatment are broken during an infant's stay at a hospital for treatment of an entirely different part of the body. There has been no testimony, and the defendants would have to concede, that Austin was not at the hospital for treatment of his legs. There is no testimony or evidence that broken legs are an inherent risk or potential complication of treatment for a respiratory condition. It is absurd for the defendants to suggest that it is beyond the common understanding of a jury to conclude that healthy legs are not broken, absent negligence, while an infant child in the exclusive control of the defendants is being treated for something totally different.

Defendants argue because the case involves medical procedures and application of the procedures, that these are not within common knowledge, and an expert is necessary. However, as noted above, it is not the question of whether the procedures would be within the common knowledge, but whether a jury can determine whether the injury would not occur without negligence as a matter of common knowledge. See Comment to SJI2d 30.05.

It is submitted that where a child is hospitalized for treatment involving areas of the body

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other than the legs, and has healthy unbroken legs upon admission, but subsequently during the hospitalization sustains two fractures of those legs, a jury can, as a matter of common knowledge, infer that the broken legs would not ordinarily occur without negligence. Expert testimony would not be needed for that.

In addition to pursuing the theory of malpractice under the doctrine of *res ipsa loquitur* without their expert, plaintiffs had also proposed in their motion for clarification regarding the necessity of expert testimony, to prove their case by cross examination of the defendants' experts, particularly Dr. Custer. The Court of Appeals did not address this aspect of plaintiffs' appeal argument. As noted above, Dr. Custer testified that if the fractured legs occurred to Austin while he was in pediatric critical care and those fractures had nothing to do with the parents, he admitted that it would be below the standard of care if the fractures occurred from mishandling and wrongly applied mechanical force. **(Ex L, Custer, pp 35-36).** See quoted testimony supra.

The circumstantial evidence here rules out any cause of the fractures other than from mishandling and wrongly applied mechanical force. As discussed extensively above, there is no evidence of abuse by the parents. There is no evidence of brittle bone disease. There is no evidence of osteomyelitis. The positive evidence is that the fractures occurred while Austin was in the care of the pediatric staff. The cause of the fractures was traumatic not pathologic. The pediatric staff performed a number of procedures on Austin which required that they handle him for insertion and removal of the feeding tube, the intubation, arterial line, left femoral central venous line, catheter and IVs. One of the lines was inserted in the groin. It was during this insertion that Kendra Reynolds observed the doctors having difficulty inserting the line, then cutting the child and bleeding occurring, with the doctors becoming agitated and the baby crying profusely. The positive evidence

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is that the fractures occurred while Austin was under the care of the pediatric critical care unit. Dr. Custer admitted if the fractured legs occurred while Austin was in that unit, it would be below the standard of care if the fractures occurred from mishandling and wrongly applied mechanical force. No cause other than wrongly applied mechanical force or mishandling could have caused these fractures. All other causes were eliminated. The breach of the standard of care is established by Dr. Custer's admission. His statement, once the qualifications are met (and they are), is binding and admissible. MRE 801(d)(2)(D). As the head of the PICU for the University of Michigan Medical Center, and an employee of the medical center, Dr. Custer's statements are binding on the hospital as well. See Bahr v Harper Grace Hospital, 198 Mich App 31, 36 (1993), 448 Mich 135, 145 (1995); Fassihi v St. Mary Hospital, 121 Mich App 11, 14 (1982). Dr. Custer's statement was made under oath during his deposition. He in essence adopted the truth of the proposition that the standard of care would be breached where the fractures occurred in the PICU, resulted from mishandling or misapplied mechanical force, and the parents were not involved. An adoptive admission is the express adoption of another statement as one's one. It is conduct on the part of a party which manifests circumstantially that party's assent in the truth of a statement made by another. Durbin v K-K-M Corp, 54 Mich App 38, 50 (1974).

Under these circumstances, plaintiffs are entitled, by cross examination of the hospital staff and Dr. Custer, to establish through their own expertise that the fractures could only have occurred during the handling of the child. The fractures, according to the defendants' doctors were traumatic. Such fractures according to Dr. Custer, where from mishandling or misapplied mechanical force, would be below the standard of care. Normally, such fractures should not occur during the procedures which were being conducted. The logical conclusion is that there was mishandling or

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misapplied mechanical force and this is not an ordinary consequence, but one resulting from negligence. Plaintiffs should be entitled to prove their case through the testimony of the adverse witnesses under MCL 600.2161. Further, the admissions of the hospital staff, particularly the head of the pediatric critical care unit, Dr. Custer, would suffice to meet the necessity of an expert even if one is required in such a case as this.

It defies logic that in a case such as this where the exact incident which caused the fractures cannot be identified, but where all other causes other than mishandling of the infant below the standard of care had been eliminated, that plaintiffs would be denied their day in court on the ground that because the expert cannot identify the event and testify as to the culpable individuals, that these plaintiff must be turned away from the courthouse door.

RELIEF REQUESTED

For the reasons stated above, this court is requested to deny the application for leave and allow plaintiffs their trial.

Respectfully submitted,

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